



FAST TRACK SERVICE AGREEMENT

I _____ understand that the long term care services that I will be receiving are temporary pending my Medicaid financial eligibility and may be authorized for a maximum of 90 days. Further, I understand the cost of these services and any future services may be subject to recovery from my estate.

I agree to apply for Medicaid by _____ (10 days from the starting date of my service). Failure to apply for Medicaid will result in the termination of my services. A determination of financial ineligibility will result in termination of my services effective the date of the determination by HCS/CSO financial services.

I understand that adjustments in my participation may be necessary when financial eligibility is determined. If I am determined to be financially eligible, my services will be extended beyond 90 days.

CLIENT SIGNATURE

DATE

WORKER SIGNATURE

DATE

OFFICE